The staff of the Suffolk County Medical Society & Suffolk Academy of Medicine would like to extend our best wishes for the upcoming New Year. We thank you for your continued support and we look forward to assisting you and your staff during 2014.

Stuart S. Friedman, MPS
Barbara Baumgarten
Donna DelVecchio
Linda LoPorto

AS A REMINDER: We will only be producing a limited number of printed Bulletins. If you would still prefer to receive one via mail, please contact us at 631-851-1400 and we will be happy to add your name to the list. Thank you for your understanding. All SCMS Bulletins can be found on our website www.scms-sam.org by clicking on Quarterly Bulletin on the left hand side.
### Suffolk County Medical Society Officers

**July 1, 2013 - June 30, 2014**

- **PRESIDENT**
  - George R. Ruggiero, DO
- **PRESIDENT-ELECT**
  - Maria A. Basile, MD
- **VICE PRESIDENT**
  - William R. Spencer, Jr., MD
- **SECRETARY**
  - Alexios Apazidis, MD
- **TREASURER**
  - Christine Doucet, MD
- **EXECUTIVE DIRECTOR**
  - Stuart S. Friedman, MPS
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  - Barbara Baumgarten
- **MEMBERSHIP/WORKERS COMP**
  - Donna DelVecchio
- **EXECUTIVE SECRETARY/ CME COORDINATOR**
  - Linda LoPorto

### Suffolk Academy of Medicine Officers

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  - Alexios Apazidis, MD
- **TREASURER**
  - Christine Doucet, MD

### Meeting Schedule

#### Executive Committee
- January 22, 2014
- March 26, 2014
- May 28, 2014

#### Board of Director
- February 26, 2014
- April 30, 2014
- June 6, 2014
  - (Annual Meeting)

All Meetings start at 6 PM and are held at the SCMS office.

### UPCOMING DATES TO REMEMBER:

- **MSSNY State Legislative Day (Albany)**
  - Tuesday, March 11, 2014
- **Review of Resolutions**
  - Wednesday, April 9, 2014
- **MSSNY House of Delegates (Tarrytown)**
  - Friday, April 11 - Sunday, April 13, 2014

### ATTENTION PHYSICIANS:

When was the last time you checked the health of your business?

We can check your well being in every business area:

- Strategic Planning
- Corporate Reorganizations, Mergers and Joint Ventures
- Federal and State Regulation Compliance, including HIPAA
- Professional Licensing and Disciplinary Proceedings
- Creation of Compliance Programs and Fraud Detection Systems
- Formation of PCs and LLCs, and Shareholder Agreements
- Contracts- Managed Care, Insurance, Management and Employment
- Defense of Medicare/Medicaid Investigations
- Hospital and Physician Privilege Disputes
- Equipment Acquisitions
- Anti-Referral Law Counseling
- Certificates of Need
- Intellectual Property Issues

**For more information contact:**

Jay B. Silverman, Partner and Co-Chair of the Health Law Department &
Chair of the Healthcare Professionals Practice Group at 516-663-6606 or email jsilverman@rmfpc.com

516.663.6600 Uniondale www.rmfpc.com

Suffolk County Medical Society Bulletin January 2014 www.scms-sam.org
President’s Page
George R. Ruggiero, DO

For years, our government has become more involved in the healthcare of its people. Medicare, Medicaid, and now the Affordable Healthcare Act, are prime examples of growing government intervention in healthcare. Regardless of your political, social, and economic views, we are watching the dust settle on one of the most dramatic shifts in governmental policy in quite some time. I believe physicians support the concept that everyone should be entitled to healthcare coverage; and support the idea of a patient going to their physician of choice, and we support the quality of the care that is delivered. However, the ideas we support are not necessarily consistent with what we are seeing being rolled out in front of our eyes. It seems the changes are coming in daily and we are actively reacting to some of these changes. It is time for everyone to become proactive.

Physicians are being dropped from insurance plans, patients are finding it more and more difficult to continue seeing their current physician, businesses are pushing to have employees insure themselves through the healthcare exchanges, and no one knows how many uninsured people have become insured at this time. This most fundamental shift in healthcare policy has not been smooth, to say the least. What is it that we, as physicians, want? We want to continue to see the patients we have already been caring for. We want the authority to be able to render the best care for our patients without unnecessary dictates from insurance companies. We would like to be able to make a fair living doing what we were trained to do. However; we do appreciate the circumstances in front of us. The government cannot afford to allow the cost of healthcare to continue to rise at its current rate. We are steadfastly against rationing care as it is against our principles. What is the compromise?

This is where we rely on our professional organizations to sit at the table and voice our needs and wants. They have the power and influence to be heard. Is your organization speaking for you? On the state and local levels, the Medical Societies are fighting for you. It is a difficult fight to be sure, but we are fighting. I strongly urge physicians to get involved and be heard. Call your legislators and pass the word in support of patient care. Let us sift through the changes and weigh in on the compromises that need to come. Continue your membership and encourage our colleagues to do the same. Contribute to MSSNYPAC so it has the funds it needs to continue on your behalf.

Finally, let us pause this holiday season to reflect on what we can be thankful for. Physicians can hold their heads up high knowing that, on a daily basis, we improve the quality of life for our patients. We are some of the most trusted people for our neighbors. Our work is measured in smiles, tears of happiness, and sometimes tears of sadness. Let us reflect on why we went into medicine. Let us reflect on the many moments in a day where you say to yourself, “What job is better than mine, and when just even one of your patients says ‘thank you doctor.’” Please take some time over the holiday season to enjoy your families and appreciate your own work. Together we will prepare for the new year ahead and all the changes therein. HAPPY HOLIDAYS to all!!!

The 2014 Medical Society of the State of New York (MSSNY) House of Delegates is scheduled to meet in Tarrytown, April 11th - April 13th. This is your opportunity to help formulate MSSNY policy for the upcoming year.

Please forward any ideas or concepts you may have to the SCMS by February 3rd to allow sufficient time for appropriate research and development.

If approved by the SCMS Board of Directors your resolution will be forwarded to the HOD for its review and consideration. Your opinion and insights are important.
Message From SCMS Councilor  
Frank G. Dowling, MD  

Warning: Your Health Insurance May Be Hazardous to Your Health!  
A Call to Action - Patients Must Make Calls, Send Letters  

For $1 Per Day, You Can Be Part of the Solution - Or Remain Part of the Problem  

The so-called “healthcare reforms” which thus far should be called healthcare changes (because reform implies improvements) imposed or resulting from the so-called Affordable Care Act, which is proving to be anything but affordable, is resulting in huge increases in costs of care and creating barriers to access care. A few items we see so far:  

- Health insurance premiums for small businesses increasing at dramatic rates- $2,000-$2,500 per month the rule, not the exception, for businesses with 2-49 employees. That’s $24,000-$30,000 per family! How can employers and their employees afford this?  

- If an employer offers insurance to an employee (no matter what the split cost - in my practice, we are splitting the cost 50-50), the employee is NOT ELIGIBLE FOR SUBSIDIES TO PURCHASE AN EXCHANGE PLAN. This means that an employer actually hurts an employee who is eligible for such subsidies if offering health insurance to that employee, unless the employee cost of premium is very low (<20%). Employers just can’t pay 80% or more of premiums this high, and of course many employees just can’t pay 50% of the premium, particularly for a family plan.  

- HIGH DEDUCTIBLES of $2,000 per person, $4,000 per family, FOR IN-NETWORK CARE other than screening or wellness visits, on and off the Exchanges. How does a typical Long Island family pay the first $2,000 out of pocket? Are the planners so foolish as to think these costs will not be obstacles? Perhaps they are sharks predicting that these costs will be obstacles which will result in: deceptively decreased costs for a few years because patients will forego care, until patients present sicker and need more care at higher cost when they can no longer avoid getting treatment; and increased profits for plans who have raised premiums by 10-25% across the board, because patients will be more reluctant than ever to see their doctor when they need to.  

- Patients do not know if their physicians will be in their Health Insurance Exchange plans and cannot find out.  

- Medicare (dis)Advantage Plan patients are receiving letters telling them their doctor is no longer in the plan.  

- Doctors are being told they are being dropped from Medicare (dis)Advantage Plans (sometimes) or they are not being given any information at all about participation.  

- Doctors who are being advised that they ARE in the health insurance exchange plans are NOT being told the fees or are being told that fees will be in the range of 50-75% of Medicare rates.  

- Since Medicare rates are already discounted and essentially unchanged for over a decade, ANY discount of these fees is a hardship that physicians just cannot be expected to bear.  

- Certainly physicians cannot be expected to offer courtesy reductions in fees to cover each patient’s $2,000/$4,000 deductible, so patients will be expected to pay 100% of their initial care the first few/several times they see their doctor each year.  

All of these changes will increase insurance company profits, further undermine the patient-physician relationship, and run the high risk of worsening access to and quality of care, when National and State - based “reforms” are allegedly designed to do the opposite.  

What can patients and physicians do? In my opinion, patients will not be able to appreciate the ramifications of these issues unless or until they are ill and directly facing the expenses and obstacles to receiving medical care. Despite this obstacle, physicians should warn their patients, and both patients and physicians should contact their Federal and State Legislators and demand that they fix this mess as soon as possible. **Patients should call their legislators and demand that they fix these problems by seeking the guidance of physicians through MSSNY and Specialty Societies.** Patients and physicians can call their legislators at the following numbers:  

(Continued on page 5)
Message From SCMS Councilor Frank G. Dowling, MD

Warning Your Health Insurance May Be Hazardous to Your Health!

A Call to Action - Patients Must Make Calls, Send Letters
(Continued from page 4)

**NY State: Call the switchboard and ask for your Senator or Assembly Member:**
NYS Senate Switchboard: (518) 455-2800
NYS Assembly: (518) 455-4100
NYS Governor: (518) 474-8390

**Federal Representatives and Senators:**
Congressman Peter King: (202) 225-7896
Congressman Steve Israel: (202) 225-3335
Congressman Tim Bishop: (202) 225-3826
Senator Kirsten Gillibrand: (202) 224-4451
Senator Charles Schumer: (202) 224-6542

Physicians should tell their legislators the same message AND should donate to MSSNYPAC and their Specialty PAC. Remind them that you provide care as well as purchase insurance. And you can’t afford either side of this disastrous problem. For $1 per day or $365 per year (suggested contribution of $175 to MSSNYPAC and $190 to Specialty PAC), we can fight for true healthcare reforms. Including the right of physicians to collectively negotiate; this is now needed more than ever, to protect patients and the patient-physician relationship itself. You cannot afford to remain on the sidelines. Your patients and family cannot afford for you to be on the sidelines. Are you angry enough to speak up and to put your money where your mouth is?

To donate to MSSNYPAC, click here or go to: https://www.mssny.org/apps/PAC/index.cfm?CFID=19626335&CFTOKEN=83095012.

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**Welcome To Our New and Returning Members**

**ACTIVE MEMBERSHIP**
Seymour Alter, MD, Smithtown; Endocrinology

**PILOT PROJECT**
Sofia Bhattacharya, MD, Northport; Internal Medicine

**NEW BROOKHAVEN MEMBERS**
Imrana Ahmed, DO, E. Patchogue; Family Medicine

**NEW MATHER/ST. CHARLES MEMBERS**
Marc Hayes, MD, Pt. Jefferson; Anesthesiology
Kenneth Levine, MD, Pt. Jefferson; Anesthesiology
Lev Lubarsky, DO, East Setauket; Internal Medicine

**RESIDENTS**
Barbara Behling-Rosa, DO, Hofstra North Shore LIJ Health System; Physical Medicine & Rehabilitation

**RE-ELECTIONS**
Vito Alamia Jr., MD, Southampton; OB/GYN
John E. Hunt Jr., MD, Southampton; OB/GYN
Allan E. Ott, MD, Southampton; OB/GYN
Florence R. Rolston, MD, Southampton; OB/GYN
Pedro R. Segarra, MD, Southampton; OB/GYN
MSSNY Treasurer
Charles Rothberg, MD

TALE OF TWO OBAMACARES

Well, it’s that time of year already – annual holiday and New Years revelry followed by the annual SGR patch (this year optimistically called a ‘bridge’ as in ‘bridge to nowhere?’). Hopefully, SGR will be repealed by con-
gress in the first quarter of 2014.

But this year is somewhat different in that the ObamaCare health plans go live. And there seems to be a tale
of two ObamaCares. For a good many Americans, ObamaCare brings health coverage for the very first time
or for the first time in a very long while.

A guy I know, Mr. GM, is a self-employed tradesperson. He’s not rich but historically earns too much for public
assistance. The past few years he has ‘chosen’ to be self-pay when he becomes a patient – kind of the same
way he ‘chose’ to become self-employed. He would have chosen to be insured if he could afford it. But the
premium on the individual market was out of reach here in Suffolk County.

He just purchased a health plan on the exchange and qualified for a subsidy. His subsidized premium is a very
affordable $184/month. While he understands that he’ll have significant cost share (50%), he takes comfort in
that he’ll get preventive services at no cost share, there are plenty of in-network doctors near his zip code, and
most importantly that his out-of-pocket will be limited to $6,350/year. He’s delighted, actually.

But too many other folks and their physicians face an unexpected disruption of their existing coverage. These
folks have maintained continuous coverage, often through the small group market (expensive, but not as punitive
as the individual market). Recently, many have received cancellation notices from their insurer. They have
been offered replacement policies with new high premiums, precedent setting cost shares and far more restrict-
tive networks than the policies they replace.

Two physicians best tell the tale of this second of two ObamaCares. The first is Dr. Patricia McLaughlin, a prac-
ticing ophthalmologist in New York City. I don’t know her well, but I know her from MSSNY. Years ago, facing
the policy challenge of the growing population of uninsured, she observed that existing programs to help these
people were undersubscribed. She would target these people and programs, yet remain cautious about
broader reforms.

Fast-forward to 2013 and ObamaCare. She has experienced the double whammy – dropped from physician
provider networks and dropped by her own health plan as it has been cancelled. She was surprised by this
double whammy because the promise of ObamaCare was that if you were happy with your insurance plan, or
if you were happy with your doctor you could keep it. But that promise is becoming a lie for too many insur-
eds. While I cannot fault the administration and congress for actions that may be those of the insurance com-
panies, I can hold them highly responsible for doing precious little about it.

The second physician is Dr. Ezekiel Emmanuel. I know him only from his policy writings (with which I often dis-
agree) and from seeing him accept an award from the AMA Foundation for his work in medical ethics, where
he awkwardly (and incorrectly) proclaimed that AMA supports his work. (Speaking with other AMA delegates
I’d say, not that much.)

Dr. Emanuel has advised the Administration on health reform and was the architect of several of its most oner-
ous provisions. He has responded publicly to the issue of cancelled policies and restrictive physician and hospi-
tal networks on the non-exchange plans awkwardly (I’m being kind – I think he’s totally tone deaf). He stated
that the issue was not at all about narrow networks. Contrary to his remarks, the issue is purely about narrow
networks. (Continued on page 7)
MSSNY Treasurer Charles Rothberg, MD
TALE OF TWO OBAMACARES

(Continued from page 6)

Most astounding, Zeke defends this reprehensible practice in the name of choice. He stated that one could choose to pay more to keep their doctor. But in most instances, one can pay, pay, pay and still not keep their doctor. I suppose they could ‘choose’ to go out-of-network (precisely the kind of choice Mr. GM made when he ‘chose’ to become self employed and uninsured). And today, fewer plans than ever offer that option at all. (Of course if you ‘choose’ the OON option, those expenses don’t apply to the newly sizable in-network deductible, and out-of-pocket maximums.) People who had insurance were promised that the reforms would come with little disruption to them. They were promised that reforms would ‘bend the cost curve’ by means of efficiencies, eliminating redundancy, eliminating waste, comparative effectiveness research, etc. - Not narrow networks and increased cost share.

Dr. McLaughlin has taken this issue to the press and has testified before Congress. She’s gaining important traction on this issue. For example, the administration has since made some exceptions for people with cancelled policies enabling them to obtain catastrophic coverage. But that’s not enough. Dr. McLaughlin suggests each of us e-mail or contact our member of Congress to remedy this important issue.

It’s funny that now we have to fight for the insured.

Practice Pays for Stolen Thumb Drive - OCR says: An Ounce of Prevention is Worth a Pound of Cure.
From the U.S. Department of Health & Human Services 12/26/2013

An Adult & Pediatric Dermatology practice in Concord, Mass., has agreed to settle potential violations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security, and Breach Notification Rules with the Department of Health and Human Services, agreeing to a $150,000 payment. They will also be required to implement a corrective action plan to correct deficiencies in its HIPAA compliance program. The group is a private practice that delivers dermatology services in four locations in Massachusetts and two in New Hampshire. This case marks the first settlement with a covered entity for not having policies and procedures in place to address the breach notification provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, passed as part of American Recovery and Reinvestment Act of 2009 (ARRA).

The HHS Office for Civil Rights (OCR) opened an investigation upon receiving a report that an unencrypted thumb drive containing the electronic protected health information (ePHI) of approximately 2,200 individuals was stolen from a vehicle of one of its staff members. The thumb drive was never recovered. The investigation revealed that the practice had not conducted an accurate and thorough analysis of the potential risks and vulnerabilities to the confidentiality of ePHI as part of its security management process. Further, the group did not fully comply with requirements of the Breach Notification Rule to have in place written policies and procedures and train workforce members.

“As we say in health care, an ounce of prevention is worth a pound of cure,” said OCR Director Leon Rodriguez. “That is what a good risk management process is all about identifying and mitigating the risk before a bad thing happens. Covered entities of all sizes need to give priority to securing electronic protected health information.”

In addition to a $150,000 resolution amount, the settlement includes a corrective action plan requiring the practice to develop a risk analysis and risk management plan to address and mitigate any security risks and vulnerabilities, as well as to provide an implementation report to OCR.

To learn more about nondiscrimination and health information privacy laws, your civil rights and privacy rights in health care and human service settings, and to find information on filing a complaint, visit us at www.HHS.gov/OCR. The resolution agreement can be found on the OCR website at http://www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/apderm-agreement.html
Why the other side hates to see us on your side.

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A Message From Your Executive Director
Stuart S. Friedman, MPS

As I seem to say every year at this time, where have the last 12 months gone? It feels like I just finished writing my 2012 year-end message and here we are again, another year upon us.

Your medical society has been extremely busy during 2013 under the expert guidance and leadership of SCMS President, George R. Ruggiero, DO.

A very successful legislative breakfast was held at the medical society office attended by almost all of our Assembly and Senate Representatives. MSSNY was represented by President-elect Andrew Y. Kleinman, MD, who helped lead the discussion on out-of-network legislation, collective negotiations and SHIN-NY (State Health Insurance Network of New York). Other pertinent topics of discussion with our elected representatives included I-STOP, Safe Act and CME mandates on Hepatitis C.

As with previous meetings of this type, the majority of legislators in attendance commented on the knowledge and expertise of our physician leaders. While they may not always agree with everything we are looking to accomplish, they welcome the opportunity to enter into honest and open dialogue with the medical society and consider us as an excellent resource on health related issues.

William R. Spencer Jr., MD, SCMS Vice President, has been re-elected for another 2-year term as a Suffolk County Legislator for the 18th Legislative District. Dr. Spencer also continues to serve as the Chair of the Suffolk County Health Committee and is the only physician to ever be elected as a Suffolk County Legislator. During the past year, he was instrumental in having legislation passed prohibiting the marketing and distribution of high-energy caffeinated drinks to children under the age of 19. Dr. Spencer was asked to testify in Washington before the U.S. Senate Committee on Commerce, Science and Technology, calling for strict guidelines to be established on a nationwide basis to help protect children and teenagers for the aggressive marketing of these dangerous high-energy caffeinated drinks.

The SCMS in conjunction with the Nassau County Medical Society, sponsored an I-STOP presentation which was attended by more than 130 physicians and office staff. SCMS Councilor, Frank G. Dowling, MD, provided cogent introductory comments and assisted in responding to many questions and concerns throughout the program. The actual program was conducted by Mr. Terrance O’Leary, Director of the Bureau of Narcotics Enforcement with the NY State Department of Health.

An ICD-10 Coding Seminar was attended by more than 60 physicians and office staff. The SCMS will be hosting other workshops on this new coding initiative which is scheduled to go into effect in October, 2014.

The SCMS has serious concerns with a proposal to close Sagamore Psychiatric Center as part of the New York State’s Regional Centers of Excellence (RCE) Plan. This ill-conceived recommendation will leave Long Island families underserved. Sagamore is the only psychiatric care facility on the Island that takes care of children and adolescents who require extended in-patient hospitalization and the only one that provides acute psychiatric care for un/under-insured children and adolescents. If closed, the closest state facility would be in the Bronx or Queens. In addition to absorbing patients from Nassau and Suffolk Counties, these remaining facilities also serve Brooklyn and Manhattan and will make both acute - care and long-term care beds less available to our most vulnerable younger population. A letter was sent to the Governor, signed by all 18 Suffolk County Legislators, urging reconsideration of closing this important facility.

It is that time of the year again when I must ask (implore) those physicians who have not yet paid their membership dues to give serious thought to what their future would be without organized medicine’s involvement on a county, state and national level. Do you honestly believe that you would be better off acting on your own without the influences, clout and oversight which accompanies your membership? (Continued on page 10)
A Message From Your Executive Director
Stuart S. Friedman, MPS
(Continued from page 9)

An unfortunate reality is that many physicians unwisely weigh their decisions to continue membership based solely upon the overall cost of dues. I would submit that in the long run, the cost of not belonging would be far greater. Medical societies, whether they are specialty, county, state or national, exist to protect and advocate for the interests of their members. While we understand that some decisions made by these organizations may, at times, be reviewed as “unpopular” or “incongruent with” a physician’s practice environment, political affiliation or philosophical outlook, it is important to remember that only organized bodies of medicine have the infrastructure, manpower and expertise to be invited to provide opinion and commentary. Please understand that without your ongoing support we become impotent in our ability to continue to effectuate meaningful change and to provide input into those issues which affect both your professional and personal lives. While your dues dollars enable us to continue to represent you, your membership and participation will enable you to continue to have a voice in your future and in the future of your profession. With the many challenges now facing the medical profession, NOW is the time for ALL physicians to come together and speak as one voice. If we are divided, we will not survive.

Let me take this opportunity to wish everyone a joyous holiday season and a very happy and healthy new year. Thank you for allowing me the opportunity to continue to serve as your Executive Director.

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Influenza 2013-2014

We are entering the 2013-2014 influenza season after last year’s season which was moderately severe with its peak in late December 2012. There are some new vaccines, as well as a new New York State Department of Health Policy regarding a requirement for healthcare personnel to either obtain the influenza vaccination or being required to wear a mask during patient interactions.

The influenza season can be followed in the weekly reports from the New York State Department of Health from October thru May of each season. Weekly reporting is available at http://www.health.ny.gov/diseases/communicable/influenza/surveillance/. Click on Weekly influenza activity reports for the 2013-2014 influenza season (PDF).

In the 2012-2013 season Influenza A (H3N2) viruses predominated overall, but Influenza B viruses and, to a lesser extent, Influenza A (H1N1)pdm09 (pH1N1) viruses also were reported in the United States. There was a higher percentage of outpatient visits for influenza-like illness (ILI), higher rates of hospitalization, and more reported deaths attributed to pneumonia and influenza compared with recent years.

More than 100 national influenza centers in over 100 countries conduct year-round surveillance for influenza. Thousands of influenza virus samples from individuals with suspected flu illness are tested and results sent to five World Health Organization (WHO) Collaborating Centers for Reference and Research on Influenza, which are located in the following places:

- Atlanta, Georgia, USA (Centers for Disease Control and Prevention, CDC);
- London, United Kingdom (National Institute for Medical Research);
- Melbourne, Australia (Victoria Infectious Diseases Reference Laboratory);
- Tokyo, Japan (National Institute for Infectious Diseases); and
- Beijing, China (National Institute for Viral Disease Control and Prevention).

To determine the vaccine components for the 2013-14 season the Vaccines and Related Biological Products Advisory Committee (VRBPAC) met on February 27, 2013 and approved for the United States the following WHO recommended composition for the Northern Hemisphere 2013-2014 influenza vaccine:

- an A/California/7/2009 (H1N1)pdm09-like virus;
- an A(H3N2) virus antigenically like the cell-propagated prototype virus A/Victoria/361/2011;
- a B/Massachusetts/2/2012-like (B/Yamagata lineage) virus.

Compared to the 2012-2013 this year’s seasonal influenza vaccine, both the H1N1 component and the H3N2 components are the same with the B component different.

This season, most seasonal influenza vaccines will have the above listed three virus components, but some quadrivalent (four-component vaccine) will also be available. Quadrivalent vaccine this year includes the three viruses listed above, and also a B/Brisbane/60/2008-like (B/Victoria lineage) virus. Therefore, this year’s vaccines protecting against three (trivalent) and four viruses (quadrivalent) will be available.

The following trivalent flu vaccines are available:

- Standard dose trivalent shots that are manufactured using virus grown in eggs. These are approved for people ages 6 months and older. There are different brands of this type of vaccine, and each is approved for different ages. [There is a brand that is approved for children as young as 6 months old and up.]
- A high-dose trivalent shot, approved for people 65 and older. (Continued on page 13)
PUBLIC HEALTH PAGE

From the Office of James L. Tomarken, MD, MPH, MBA, MSW, FACP, FRCPC
Commissioner of the Suffolk County Department of Health Services

(Continued from page 12)

• A standard dose trivalent shot containing virus grown in cell culture, which is approved for people 18 and older.
• A standard dose trivalent shot that is egg-free, approved for people 18 through 49 years of age.
• A standard dose intradermal trivalent shot, which is injected into the skin instead of the muscle and uses a much smaller needle than the regular flu shot, approved for people 18 through 64 years of age.

The following quadrivalent flu vaccines are available:

• A standard dose quadrivalent shot.
• A standard dose quadrivalent flu vaccine, given as a nasal spray, approved for healthy (no underlying medical conditions predisposing to influenza complications) people 2 through 49 years of age.

A list of approved vaccines available this season is available at http://www.cdc.gov/flu/protect/vaccine/vaccines.htm.

The CDC does not recommend a specific flu vaccine or trivalent vs. quadrivalent vaccine or injection (the flu shot) vs. nasal spray vaccine. The emphasis is on receiving a flu vaccine every year.

All those who are at least 6 months of age should get a flu vaccine this season. This recommendation has been in place since February 24, 2010 when the CDC’s Advisory Committee on Immunization Practices (ACIP) voted for “universal” flu vaccination in the United States to expand protection against the flu to more people.

The New York State Department of Health’s 2013-14 flu season “Prevention of Influenza Transmission by Healthcare and Residential Facility and Agency Personnel” regulation requires “personnel in healthcare and residential facilities and agencies whose job activities are such that they could expose patients or residents to influenza” to either obtain a flu vaccination or wear a mask when the NYS Health Commissioner determines influenza to be “widespread.” Widespread indicates increased or sustained numbers of lab-confirmed cases of influenza reported in at least 31 of the 62 counties.

This regulation is described on the New York State Department of Health website at http://www.health.ny.gov/professionals/nursing_home_administrator/dal_nh_13-04_flu_mask_requirement.htm.

The Frequently Asked Questions document provides valuable information as well, including when the policy becomes effective.

It is with deep regret we announce the passing of Richard Griffin Lennon, MD, on September 8th, 2013.

Dr. Lennon graduated from Cornell University Medical College in 1964, he completed his internship at Bellevue Hospital. While an intern, he was recruited by the CDC in Atlanta and spent two years as an E.I.S. officer. In 1970, Dr. Lennon joined the practice of Drs. Paton and Bronson at Southampton Eye Physicians and Surgeons, where he became a partner. He brought the first effective ocular laser to Long Island in 1971.

Dr. Lennon had been Chief of Surgery at Southampton Hospital, he was instrumental in establishing the Outpatient Surgical Department in 1987, and was elected President of the Medical Staff and served 16 years on the Board of Directors of the hospital.
You May Not See Us, But We Are There.

MSSNY/SCMS’s persistent efforts, made possible through your membership, have an enormous impact on your day-to-day experience, even though you may not always realize it.

Because MSSNY/SCMS so regularly defeat proposals that would exacerbate the difficulties physicians are having in practice today, you don’t have to think about:

- Continued funding of the free, excess layer of liability coverage MSSNY/SCMS secured to protect physicians’ personal assets in case of outsized awards — a $5,500 benefit to each of the 24,200 physicians currently enrolled in the program.
- Even higher medical liability premiums than you pay now — MSSNY/SCMS defeated a bill which would have lengthened the statute of limitations for medical liability claims this year, deflecting a 15% increase in your medical liability premium rates. Each neurosurgeon in downstate communities saved $45,000; each OB GYN in Nassau and Suffolk County saved $31,000; and each internist-cardiologist in Buffalo saved $13,000.
- Retail clinics and nurse practitioners creating separate and fragmented silos of care delivery.
- Legislation mandating that physicians meet onerous requirements for pain management CME.
- An even more burdensome I-STOP program.
- Even more unfair managed care business practices and less physician-friendly contract provisions.
- Over 30 bills that would expand various non-physician scopes of practice that did not pass.

All of these issues affect you directly, or they affect what your employer pays you. And they affect your status as part of the healthcare team. No one can represent you on issues like these as effectively as MSSNY/SCMS.

Thank you for sending your 2014 dues today.

Sincerely,

George Ruggiero, DO  
SCMS President

Sam L. Unterricht, MD  
MSSNY President
STATE LEVEL ACTIVITY

MSSNY Continues its Work on Out-Of-Network Legislation

Members of MSSNY’s leadership and your DGA have continued to work on resolving outstanding issues with regard to the Out-of-Network legislation passed earlier this year by the NYS Senate. Meetings have been held with Senate Health Committee Chair, Kemp Hannon; Assembly Insurance Committee Chair, Kevin Cahill; Commissioner Nirav Shah, MD and others to lay the foundation for enactment of an Out-of-Network bill in 2014. While we remain optimistic, much more work is underway to address concerns regarding the Fair Health Database. MSSNY’s President-elect, Andrew Kleinman, MD, recently spoke with Robin Gelburd, President of Fair Health Inc., to request that she educate Assemblyman Cahill concerning how the integrity of the Fair Health database is maintained. Dr. Kleinman and MSSNY lobbyists are also speaking with members of the Governor’s staff with a view toward possibly including this measure in the Governor’s proposed budget for 2014. This issue remains at the top of MSSNY’s priority list. MSSNY is planning a lobby day on this issue in January and may align the lobby day with a Senate Health Committee Round Table.

MSSNY Continues to Advocate for Physicians to be Treated Fairly By Insurers Offering Coverage in the Exchange

A survey by MSSNY of its physicians regarding their interactions with health insurers offering coverage in the New York State Health Insurance Exchange was the subject of articles recently in the New York Post, as well as the Albany CBS Affiliate. MSSNY continues to urge physicians to complete the survey so that it is more representative of physician experiences statewide. If you have not already done so, we urge you please complete the survey here http://www.surveymonkey.com/s/nyhealthexchange.

MSSNY representatives have had extensive and near daily communications with staff of New York’s Exchange to make them aware of concerns being raised by physicians.

MSSNY President Sam Unterricht, MD, issued the following statement regarding the survey:

“As reported in the New York Post, MSSNY’s physician survey preliminarily shows that there is a lot of confusion and concern among physicians regarding the information, or in some cases lack of information, being provided by health insurance companies offering coverage in New York’s health insurance exchange.

MSSNY has worked proactively with the officials in the New York State Department of Health and Department of Financial Services as the Exchange was being implemented to assure that consumers and employers are able to obtain comprehensive health insurance coverage, and that networks are sufficiently sized to assure that patients are able to obtain the timely and quality care they deserve. The purpose of the survey is to ascertain from physicians their experiences whether they were being treated fairly by health insurance companies offering products in New York’s Health Insurance Exchange.

While responses are continuing to come in, the initial response of over 400 physicians showed that over 40% of the respondents did not join the panel of a health insurer Exchange product, but also that a full 1/3 of physician survey respondents actually did not know whether they were participating in an Exchange plan or not. This may be the result of a lack of necessary information being provided to physicians by health insurance companies with whom they may currently have participation agreements for other product lines sold by that company. Further investigation is warranted. (Continued on page 16)
Another concern raised was the lack of available fee information for the care that will be provided to patients enrolled in these Exchange products. According to the survey, over 2/3 of the physician respondents indicated that they had not received any information from health plans regarding the reimbursement that they would receive for providing this care. It is worth noting that New York State has longstanding law that requires health insurers to provide participating physicians with relevant fee information. And of those physicians who did receive fee information, a significant majority indicated that the reimbursement generally was well below what the insurer pays in other contracts.

These survey results present an initial picture of concerns that physicians have seen so far regarding their dealings with health insurers offering coverage on the Exchange. We intend to present these concerns to state officials to assure that these concerns are addressed and patients are able to receive the care they expect to receive in purchasing this coverage.”

The NYS Department of Health announced that nearly 174,000 New Yorkers had completed the full application process and were determined eligible for health insurance plans since the Oct. 1 launch, and that over 37,000 New Yorkers have fully enrolled for health insurance through the NY State of Health marketplace. Of the over 37,000 fully enrolled, over 23,000 were eligible for Medicaid coverage.

**New York State Department of Health (DOH) and New York eHealth Collaborative (NYeC) working to enhance functionality and participation on the State Health Information Network (SHIN-NY)**

The State Health Information Network of New York (SHIN-NY) is a secure network for sharing clinical patient data across providers of health care in New York State through Regional Health Information Organizations (RHIOs). The SHIN-NY is coordinated by the New York e-Health Collaborative (NYeC) in conjunction with the New York State Department of Health, and the state’s 11 RHIOs. Until now, the relationships of those who developed the framework of the SHIN-NY and RHIOs have been defined by state HEAL grant contracts which will terminate at the end of the state’s fiscal year. DOH and NYeC have developed new contractual agreements and proposed regulations which will define the operational responsibilities respectively of DOH, NYeC and Qualified Entities (formerly RHIOs) in continuing to provide a myriad of services to support intra-operative transfer of health information in the future. Moreover, the DOH has developed soon-to-be published regulations which will establish the relationships and duties of these parties as well as the standards to be followed by these entities and by participating physicians, hospitals and other stakeholders in the transmission of health information through the SHIN-NY. Importantly, the proposed draft will require entities currently regulated by the Department of Health such as hospitals and federally qualified health centers to participate on the SHIN-NY within two years of the effective date of the regulations.

Earlier this year, MSSNY advocacy resulted in the rejection of a draft proposal to require physicians to participate on the SHIN-NY by linking participation to re-registration of physician licensure. This proposal has been removed from the list of proposals the Department will advance in the legislative arena in 2014.

In addition, MSSNY leaders including Richard Peer, MD and Malcolm Reid, MD have participated on a workgroup appointed by Commissioner Shah to allocate funding to continue the operation of the SHIN-NY, QEs and NYeC over the next three years. It is anticipated that $72.8M from federal, state and HCRA monies will be appropriated annually for this purpose. It is further anticipated that RHIOs will complete a “gap analysis” as part of a provisional certification process during Q4 2013 and that full certification of the QEs will be completed by the Q1 2015. Minimum requirements for inter and intra-community connectivity will be established with the view toward achieving full functionality by March 2015. While much of the funding early on will be devoted to gap analysis and achieving the minimum data sharing requirements across all communities in NYS, a large amount will also be devoted to enhancing SHIN-NY adoption by physicians and other stakeholders. (Continued on page 17)
Federal Level Activity

Senate Finance, House Ways & Finance Offer Joint SGR Repeal Proposal

The U.S. Senate Finance Committee and U.S. House Ways & Means Committee recently released a joint “discussion draft” of a proposal to repeal the flawed SGR Medicare physician payment formula and replace it with a new payment system. The proposal is substantially different than legislation passed by the House Energy & Commerce Committee earlier this year. To read the “discussion draft”, go to: http://waysandmeans.house.gov/uploadedfiles/sgr_discussion_draft.pdf

According to a summary provided by the AMA, some of the key provisions in the draft proposal include:

- The SGR formula is repealed.
- Annual fee schedule payment updates would be frozen for 10 years; annual positive updates would begin in 2024.
- A new “value-based performance (VBP) payment program” would be used to adjust payments beginning in 2017. This new VBP program essentially combines all the current incentive and penalty programs (e.g., value-based modifier, meaningful use, PQRS) into one budget-neutral program. Payments could be increased or decreased significantly, depending on how well a physician scores relative to others on a composite performance score.
- Physicians participating in certain alternative payment models, including the patient-centered medical home, would be exempt from the VBP program. Revenue thresholds are established for APMs other than the medical home model, and two-sided risk and a quality component would be required to qualify for a 5% bonus in 2016-2021.
- Several proposals to “ensure accurate valuation of services” under the physician fee schedule are made. Over a three-year period, misvalued codes would have to be adjusted to achieve 1% in total fee schedule savings to avoid reductions in the total physician payment pool. In addition, the Secretary of HHS would initiate a data collection effort on resource use requiring selected physicians to submit data (CMS may provide some compensation to the physician for doing this) or face a one-year, 10% payment reduction.
- Appropriate use criteria would be applied to certain imaging services; prior authorization requirements would be imposed on outliers.
- HHS would publish utilization and payment data for physicians on the Physician Compare website.

AMA President Dr. Ardis Hoven offered the following comments on the proposal:

“The AMA commends the Senate Finance Committee and House Ways and Means Committee for collaborating in a bipartisan, bicameral process to end the failed Medicare funding formula known as the sustainable growth rate, or SGR. Building on the strong foundation laid this summer by the House Energy and Commerce Committee, the framework released late yesterday is an encouraging development, and represents a pivotal step toward stabilizing and improving the Medicare program on behalf of America’s seniors and physicians.

Congress is demonstrating that they understand that ending the failed SGR this year is fiscally responsible, and that the current Medicare payment system is a barrier to adoption of healthcare delivery and payment reforms that will improve health care for America’s seniors and rein in overall costs.

AMA is currently analyzing the recently released summary, and looks forward to continuing the constructive, bipartisan dialogue that has characterized this process as preparations are made for moving legislation forward.”

(Continued on page 18)
Report from MSSNY’s Division of Governmental Affairs
(Continued from page 17)

MSSNY staff has been in touch with the offices of Senator Schumer, Representative Joe Crowley and Representative Tom Reed (both members of the House Ways & Means Committee) to receive an initial briefing on this proposal. We indicated that we will continue to review the proposal, and that a concrete proposal to advance SGR repeal discussions is helpful. However, we also indicated that New York’s physicians are likely to have very significant concerns with a proposal that would lock in place for a decade already insufficient Medicare payments while also threatening further steep cuts to many physicians who cannot absorb these cuts.

Please remain alert for further updates. Physicians should also continue to contact Senators Schumer and Gillibrand through MSSNY’s Grassroots Action Center to send a letter in support of SGR repeal (http://capwiz.com/mssny/issues/alert/?alertid=62924231&type=CO&show_alert=1). Physicians can also use the AMA’s Grassroots Hotline at 1-800-833-6354.

Many MSSNY physician leaders will be advocating on Capitol Hill on November 19th, in conjunction with the AMA Interim HOD meeting.

PHYSICIAN RANKINGS AND RATINGS: A NEW KEY TO SUCCESS (AND SURVIVAL)

By: Michael J. Schoppmann, Esq.

Throughout the medical field in the United States, a new set of questions has arisen which physicians and medical practices should be asking themselves. These questions, and their potentially surprising answers, can determine whether or not a practice retains its participating status by a health plan (private and/or public); whether the reimbursement rates a practice is receiving are increasing (or dwindling); whether the practice is at an increased risk of an adverse investigation or action; and/or whether or not the practice is experiencing the loss of a significant portion of patient flow.

What places medical practices and physicians at an even higher risk of encountering problems in any or all of these areas is that physicians and practices are completely unaware of their ranking in these areas or they do not recognize the need to address this new set of questions. What a physician and/or a medical practice does not know may actually pose a greater risk than what is known. As but one example, there is no method or resource available for purchase which can tell physicians or medical practices what patients choose not to utilize their services. However, by addressing (and continuing to readdress) a basic set of questions, physicians and medical practices can become aware of what may be threatening their very survival, take measures to counteract any negative ranking and/or rating and turn these ranking and/or rating systems into positive assets for their future success.

This new set of questions, in primary terms, is as follows:

▪ Where are we ranked and/or rated?
▪ Who is ranking and/or rating us?
▪ How are we ranked and/or rated?
▪ What is the potential and/or present impact of the rankings and ratings?

In breaking down the analysis of these questions into the sub-categories of (1) payors and (2) patients, the payor analysis bears the higher priority. As medicine continues to spin off into countless new pilot projects of differing and untested “payment models,” there is one constant found in each construction – that physicians and medical practices will be examined, evaluated, measured and judged. Terms such as “pay for performance,” “physician performance,” “practice benchmarking” and “value based purchasing” are all now cornerstones of every healthcare reform initiative. However, what most practices and/or physicians do not grasp is the fact that the information gathered through these initiatives is not being compiled for academic or research analysis. Each and every aspect of “physician performance measurements” carries the added elements of “measurement and reporting.” (Continued on page 19)
In today’s medicine, data is compiled to be used actively and aggressively – in ways every physician must be aware of and act upon.

In the payor realm, these terms have been in development for years and are already being acted upon and imposed onto physicians and practices by both private and public payors. Some health plans, such as Aetna and United Healthcare, have developed "tiered" physician networks based on their own definitions of quality and efficiency – derived from their own “performance data.” Health plans then use this information to “rank” or “grade” a physician/medical practice and encourage patients to seek care from these “high-performing” practices (at the expense of other practices which the health plan has determined not to be “high-performing”). Failing to meet these new performance standards may also result in a termination or non-renewal of the practice/physician’s participating agreements – which, in certain market-share settings, can be a death blow to the practice.

Risk managing the payor equation, every physician and/or medical practice should immediately contact each of their payors and obtain any and all “performance,” “quality” and/or other policies, protocols or set of standards which exist and/or have been imposed upon the practice by the payor. The practice should then review, closely, each of these performance evaluation measurements and either make changes to meet the imposed requirements or evaluate the financial viability of having the practice terminate its participation with the payor. If the payor is utilizing a “ranking” system, the practice must immediately verify its ranking and challenge any ranking that does not place it at the highest level.

In the public realm, practices and physicians can no longer ignore or discount the ever expanding number of “ratings” sites under which they appear - and are judged. While practices and physicians may have never enrolled in such sites, or even be aware of the fact that they appear on these sites, their presence exists and, in many cases, reveal how they may be adversely attacked by members of the public.

Risk managing the public equation, every practice and physician should set a routine and unswayable schedule of online credentialing - the act of taking the name of the practice, the names of each of the physicians employed by the practice and seeking out their rating on each of the commonly utilized rating sites (i.e., Vitals, Healthgrades, Ratemds, etc.) and (1) verifying the data included is correct, up to date and accurate and (2) challenging any adverse ratings – within the methods for doing so set by the ratings site.

In conclusion, ratings and rankings are broad titles for foundational changes to the standards every physician/medical practice must meet. Acting in defiance of these standards, or continuing to practice in ignorance of them, will only result in the imposition of devastating consequences – some of which will only be manifested in a manner from which the practice cannot recover. To survive, and to succeed, aggressive and preemptive risk management must be adopted, implemented and adhered to by every physician and medical practice.

Kern Augustine Conroy & Schoppmann, P.C., Attorneys to Health Professionals, DrLaw.com, is solely devoted to the representation and defense of physicians and other health care professionals.

FROM THE DESK OF MSSNY PRESIDENT SAM UNTERRICHT, MD

The New Year brings dangerous weather and dangerous new billing and administrative problems. Physicians are used to dealing with new insurance plans, new deductibles and new ‘gotchas’ every year. These dangers have never been more acute than in 2014, with the rollout of the ACA and the Exchange plans. Here are some snow shovels and kitty litter you can use to avoid falling due to the slick feds and the slippery insurance companies:

- Physician’s staff should confirm physician’s participation status with the link to New York State of Health table of insurers. You need to check each insurer’s website separately; you may be amazed at how many of the Exchange Plans you are participating in! (Continued on page 20)
FROM THE DESK OF MSSNY PRESIDENT SAM UNTERRICHT, MD

(Continued from page 19)

• Patient ID cards must be checked very carefully, as they probably will not indicate which ‘metal plan’ patients are in and what their deductible is. In fact, while Exchange plans are supposed to be identified by ‘Ex,’ it may be difficult to identify Exchange Plan patients as opposed to some commercial-plan patients.

• Other important information may not be found on insurance cards. For example, only patients receiving assistance toward their premiums are subject to the 90-day grace period, but those patients are not identified on the insurance card for ‘privacy reasons;’ you must inquire when you call the insurance company whether the patient is in the last 60-days of the grace period. If you are, your claim will be pended and if they do not pay the insurance company the premium due, your claim will be denied.

• Physicians should, if possible, call the insurance company (since the insurance company website may be less up-to-date) to determine:

  1. Patient eligibility
  2. Deductible not yet satisfied (up to $5000 for Bronze or Silver Plans may have to be paid out of pocket before any benefits are paid)
  3. Grace period status, beginning in February

• There are preventive services for adults, women and children that must be covered without any patient cost-sharing (whether inside or outside the Exchange). For a list, click here or go to: https://www.healthcare.gov/what-are-my-preventive-care-benefits

• Physicians should determine the fee approved by each insurance company, which is usually given as a percentage of Medicare, in order to make a business decision whether to participate in a given Exchange product or to decide how much of an estimated fee to collect in advance in case of unmet deductibles or last 60 days of the grace period.

• According to our phone call recently with the NYS DOH, physicians may collect the estimated fee or deductible in advance if the deductible has not been met or if the patient is in the last 60 days of the grace period. Clearly, there are practical and legal pitfalls involved in this practice. Here is advice from Donald Moy, Esq., partner in Kern Augustine Conroy & Schoppmann, P.C.: “We have seen numerous medical practices adopt a policy of requiring patient to pay deductible or co-payment amount at the time of service. If a medical practice adopts the practice, patients should be informed in advance of the policy. Preferably, patients should be informed at the time that the appointment is scheduled. Physician should check each health plan to verify patient eligibility for covered services. Most health plan participation agreements require physician to follow health plan member eligibility verification procedures. The problem is some health plan web site information may not be quite up to date, but eligibility verification procedures should be followed. With some health plans it may be possible to obtain the patient’s current remaining deductible amount. If the medical practice has incorrectly determined the outstanding deductible amount it may be necessary to refund the patient for any amount that was charged to the patient above the patient’s outstanding deductible.

May a medical practice decline to accept an individual as a patient because of the patient’s health plan coverage status? In general, a physician is not required to accept an individual as a patient. However, once the physician-patient relationship has commenced, the physician may not abandon the patient and depending upon the circumstances, must continue to provide treatment or provide reasonable notice of withdrawal. While a physician is not required to accept an individual as a patient, a physician may not refuse an individual on the basis of race, religion, nationality or other ground that constitutes unlawful discrimination. A physician needs to also check the policies and procedures of each health plan in which the physician participates to ascertain if the health plan has specific rules or procedures pertaining to declining to accept covered health plan members as patients.”

Preliminary results of our new survey show that 49.4% of physicians surveyed are considering opting out of the Exchange. If a physician decides to opt-out of an Exchange plan, they need to check their contract or carrier to determine the proper way to do this. If there is an ‘all-products-clause’ in the contract, it may be difficult to opt out of the Exchange without opting out of the commercial and Medicare Advantage Plans, as well.
LEARN THE REAL ISSUES OF ESTATE ANALYSIS & RETIREMENT PLANNING

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Preserving Your Pension/IRA/Keogh Assets
Using Trusts in Estate Analysis
Creative Uses of Life Insurance
Planning for Families with Disabled Children
Disability Income Insurance
Business Agreement Funding
Group Health Insurance
Evaluation of Long Term Care Insurance Policies
Investments*

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_WE NOW HAVE THE NEW BIODEX COMPUTERIZED BALANCE SYSTEM_

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Dear Colleague:

On October 23, 2013, Governor Andrew M. Cuomo signed into law a new Section 2171 of the Public Health Law requiring the offer of a hepatitis C screening test to every individual born between 1945 and 1965 receiving inpatient hospital care or primary care. This new law will take effect January 1, 2014.

In the U.S., an estimated 2.7 million to 3.9 million people are living with hepatitis C virus (HCV) infection. It is estimated that up to 75 percent of persons living with HCV do not know their status. The Centers for Disease Control and Prevention (CDC) estimates individuals born during 1945 to 1965 account for approximately three-fourths of all HCV infections in the U.S. and 73 percent of HCV-associated mortality, and they are at greatest risk for liver cancer and other HCV-related liver disease. With the advent of new therapies to stop disease progression and cure most persons, testing and linkage to care for infected persons in this birth cohort are expected to reduce HCV-related morbidity and mortality.

Statewide, an estimated 200,000 New Yorkers are living with HCV infection, with an estimated 150,000 unaware of their HCV status. The new law was enacted to increase HCV testing and ensure timely diagnosis and linkage to care.

The New York State Hepatitis C Testing Law is in line with recommendations issued by the CDC and the U.S. Preventive Services Task Force. The new law requires:

- A HCV screening test be offered to every individual born between 1945 and 1965 receiving health services as an inpatient of a hospital or receiving primary care services in the outpatient department of a hospital or in a freestanding diagnostic and treatment center or from a physician, physician assistant, or nurse practitioner providing primary care unless the health care practitioner providing such services reasonably believes that:
  - the individual is being treated for a life-threatening emergency; or
  - the individual has previously been offered or has been the subject of a hepatitis C screening test (except that a test shall be offered if otherwise indicated); or
  - the individual lacks capacity to consent to a hepatitis C screening test.

- The law further requires that if an individual accepts the test offer and the screening test is reactive, the health care provider must either offer the individual follow-up health care or refer the individual to a health care provider who can provide such care, including a hepatitis C diagnostic test.

- The offer of testing must be culturally and linguistically appropriate in accordance with rules and regulations promulgated by the Commissioner of Health.

For additional information, please visit the New York State Department of Health website (www.nyhealth.gov) or the New York City Health Department website (www.nyc.gov/health). Questions regarding the HCV testing law may be sent to hepactbc@health.state.ny.us.

Along with new, more effective HCV treatments, this new State law provides an opportunity to increase the number of persons aware of their HCV status, link them to appropriate medical care and treatment, and provide them a possible cure for HCV.

Thank you for your commitment to keeping New Yorkers healthy.

Sincerely,

Nirav R. Shah, M.D., M.P.H.
Commissioner of Health
WANT TO REDUCE YOUR COUNTY AND STATE SOCIETY DUES?

The Medical Society of the State of New York has joined with The Suffolk County Medical Society in offering the following dues incentive program for physicians who help recruit new members to the medical society:

- Recruit 1-2 full dues paying members; receive a $150 refund ($75 county/$75 state) for the current dues year;
- Recruit 3 or 4 full dues paying members; receive a $430 refund ($200 county/$230 state) for the current dues year;
- Recruit 5 full dues paying members; pay no county and state society dues for the current dues year.

Young physicians (under the age of 40 or in practice less than 5 years) qualify for a graduated dues structure as follows:

For calendar year 2014, young physicians who elect to join the medical society are required to pay only $200 in dues ($100 county/$100 state); in 2015 the dues rate increases to $430 (50% county/50% state); in 2016 to $645 ($300 county/$345 state); and in 2016 to $860 (full county and state dues).

Suffolk County members who help recruit young physicians are entitled to the following reductions in both county and state society dues.

- Recruit 3-4 young physicians; receive a $150 refund ($75 county/$75 state) for the current dues year;
- Recruit 5-6 young physicians; receive a $300 refund ($150 county/$150 state) for the current dues year;
- Recruit 7 or more young physicians; pay no county and state society dues for the current dues year.

In order to receive the appropriate refund, new members must identify the name of the physician who recommended them on the membership application. Please be sure to have referring physician contact SCMS when dues statement is received.

Physicians who recruit any number of non-members will have their name prominently displayed in the SCMS BULLETIN.

It is only through understanding and mutual cooperation that the medical society can thrive in this rapidly changing healthcare environment. We cannot do it alone – we need your commitment and assistance.

Together we can accomplish great things.

24% Medicare Payment Reduction Averted

On December 26, 2013, President Obama signed into law the "Pathway for SGR Reform Act of 2013" that includes among other provisions, a 3-month delay of the 24% Medicare SGR physician payment cut that was scheduled to go into effect January 1, 2014. The 3-month "bridge" also includes a 0.5% update for claims with dates of service on or after January 1, 2014 through March 31, 2014. It should also be noted that while the law mitigated some of the cuts to federal programs imposed as a result of the sequestration, it left in place the vast majority of the $1 trillion in sequestration cuts imposed earlier in 2013.

Serious discussions regarding a proposal to enact a full repeal of the SGR are occurring on a parallel track and will continue in early 2014. The House Ways & Means and Senate Finance Committee have each passed similar SGR repeal proposals. President Obama remains committed to a permanent solution to eliminating the SGR reductions and will continue to work with Congress to achieve this goal.

2014 Medicare Physician Fee Schedule can be found online by CLICKING HERE
Or go to www.NGSmedicare.com
Select Jurisdiction K Part B, Quick Links - Fee Schedule on the left sidebar
RETIREMENT PLANNING FOR 2013 & 2014!!!
UPDATING YOUR ANNUAL QUALIFIED RETIREMENT BENEFIT LIMITS

The Internal Revenue Service recently announced the 2014 inflation-adjusted Pension Plan Limitations, which are detailed below. In summary, certain pension plan contribution limits, such as those governing 401(k) plans and IRAs, remain unchanged because the increase in the Consumer Price Index did not meet statutory thresholds for triggering their adjustment. However, other pension plan contribution limits increased slightly for 2014.

Remember, the key advantage to qualified retirement plans is that your contributions are tax deductible and grow tax-deferred. This will result in more dollars for your retirement years. In addition, for most readers who are self-employed, there is tremendous flexibility in selecting the appropriate plan to maximize your contributions.

### QUALIFIED PLANS - MAXIMUM ANNUAL CONTRIBUTIONS

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<td>Total for 401(k), 403(b), and 457 plans</td>
<td>$23,000</td>
<td>$23,000</td>
</tr>
<tr>
<td>Savings incentive match plans for employees (SIMPLEs)</td>
<td>$12,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>50+ Catch up</td>
<td>$2,500</td>
<td>$2,500</td>
</tr>
<tr>
<td>Total for SIMPLEs</td>
<td>$14,500</td>
<td>$14,500</td>
</tr>
<tr>
<td>Traditional and Roth IRAs</td>
<td>$5,500</td>
<td>$5,500</td>
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<tr>
<td>50+ Catch up</td>
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</tr>
<tr>
<td>Total for Traditional and Roth IRAs</td>
<td>$6,500</td>
<td>$6,500</td>
</tr>
</tbody>
</table>

Don’t forget the "catch up provisions" for those individuals who are age 50 or older!! These additional amounts will not only save on your taxes, but also will help cushion your retirement nest egg!!

**Determining Your Best Retirement Program!!!**

The key to maximizing your retirement contributions and minimizing your taxes today is to select a retirement program that works best for your professional practice.

AND REMEMBER, PEOPLE DON’T PLAN TO FAIL, THEY JUST FAIL TO PLAN.................
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Dedicated to playing an important role in shaping the future of malpractice insurance.

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- PRI protects top doctors and the leading healthcare facilities in New York, using our unique, award winning risk management and loss prevention techniques.

- PRI successfully defends doctors with the strongest defense team anywhere and the most aggressive approach to defeating unjust claims, effectively insulating our insured against fraudulent, capricious claims.

Suffolk County Medical Society Bulletin January 2014 www.scms-sam.org
At one time in America, there was no such thing as "health insurance." Patients negotiated directly with hospitals and doctors, and paid what they could, often on a sliding scale, according to ability. Eventually, health insurance entered the market, easing the burden of healthcare costs.

It didn't take long to realize the ordinary rules of supply and demand would not apply, if the insurance company, not the patient, was responsible for the bill. Copayments, deductibles, and coinsurance developed as a check against overutilization. If the patient had some "skin" in the game, this would provide some disincentive, though not absolute, but some hedge against over-use. This protective requirement, though necessary, is at times at odds with AMA Code of Ethics Opinion 8.03, which holds: "The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration."

In the current economy, as available dollars are becoming scarce, insurance carriers have begun checking up on the collection of copayments, deductibles, and coinsurance. With greater regularity, physicians and hospitals are receiving letters requesting proof, in perhaps five randomly selected cases, that the provider has collected, or sufficiently attempted to collect the portion of fees which is the patient's responsibility. This comes as a shock to many providers, who in keeping with Opinion 8.03, and the historical tradition of sliding scales, based upon ability to pay, have subordinated financial ability to pay in favor of the higher duty to care for the patient's need.

It is important to understand, however, forgiveness of copayments could land you in hot water. Therefore, doctors must understand the rules regarding waiver of copayments. AMA Opinion 6.12 addresses the ethical considerations:

**Opinion 6.12 - Forgiveness or Waiver of Insurance Copayments**

Under the terms of many health insurance policies or programs, patients are made more conscious of the cost of their medical care through copayments. By imposing copayments for office visits and other medical services, insurers hope to discourage unnecessary healthcare. In some cases, financial hardship may deter patients from seeking necessary care if they would be responsible for a copayment for the care. Physicians commonly forgive or waive copayments to facilitate patient access to needed medical care. When a copayment is a barrier to needed care because of financial hardship, physicians should forgive or waive the copayment.

A number of clinics have advertised their willingness to provide detailed medical evaluations and accept the insurer's payment but waive the copayment for all patients.

Physicians should be aware that forgiveness or waiver of copayments may violate the policies of some insurers, both public and private; other insurers may permit forgiveness or waiver if they are aware of the reasons for the forgiveness or waiver. Routine forgiveness or waiver of copayments may constitute fraud under state and federal law. Physicians should ensure that their policies on copayments are consistent with applicable law and with the requirements of their agreements with insurers.

Where the insurance contract requires a doctor to make reasonable attempts to collect the patient's portion, an open question surrounds the definition of "reasonable attempts to collect the debt." Historically, doctors could satisfy the requirement by sending at least three letters attempting to collect the debt. However, the Office of Inspector General (OIG) has taken the position that the routine waiver of copayments could constitute a criminal kickback in Medicare cases.

This has emboldened private insurers, who are relying upon this contractual provision as a basis for a post-payment recoupment audit. If a provider cannot demonstrate efforts to collect from the patient, the carrier may demand a refund for any benefits paid across a large patient population.

Providers should be aware of this new emphasis upon patient responsibility. My advice would be to proactively get ahead of the problem. Contact your insurance representative to find out what is expected of you and document the response. By all means, if you are a physician and you receive a letter from an insurance carrier requesting proof of attempts to collect, do not ignore it. A failure to cooperate could constitute grounds for termination of the contract with the payer.

Because this emphasis upon collection of copayments is a fairly recent phenomenon, even if you have been deficient in the past, you may be able to satisfy the carrier by demonstrating a corrective plan of action going forward.
How Verifying Patient Benefits Can Increase Revenue in 2014
Reprint from Physicians Practice.com December 20, 2013 | By Matt Dallmann

It is typical for the beginning of each calendar year to bring an increase in patient copays, co-insurance, and deductibles. However, with the implementation of the Affordable Care Act, 2014 will likely bring a larger increase than usual. Most of the insurance plans offered in the New York State Insurance Exchange, for example, have substantial deductibles, and none of them offer out-of-network benefits. And many of the patients enrolling in these plans have little to no knowledge of their coverage. Additionally, as providers, you may be unaware of which plans you participate with. It is possible to only participate with select plans offered by an insurer, so you may tell a patient you are participating with UnitedHealthcare, only to discover that you don’t participate with the UnitedHealthcare product they purchased on the exchange.

So what can you do to save time and avoid coverage problems? You need to be proactive. Start by logging into your state’s health insurance exchange and look at the plans that are offered. If you are not sure that you participate with a given plan, make a note of the specific plan or product name - i.e. Empire Blue Cross Blue Shield Pathway Network - then contact your provider services representative to check if your tax ID or NPI is listed as participating for those specific plans or networks. Then check the benefits descriptions for each plan offered on the exchange, which will show a breakdown of applicable deductibles and non-covered services. Compile a cheat sheet for your front-desk staff, so when a new patient with a plan from the exchange calls you can quickly determine whether or not services are covered.

The insurance plans offered on the health exchanges are not the only ones you need to worry about. Small group and individual plans offered outside the health exchanges must also be compliant with the healthcare reform law by their renewal date, which is typically January 1, April 1, or July 1. Again, it is likely that copays will increase, and plans may be subject to a co-insurance or deductible for the first time. Patients may be unaware that their plan has changed, so they may get upset when they receive a bill. And unless you have a system in place to verify benefits and communicate the changes to the patient, you may lose money.

You may argue that it is the patient’s responsibility to understand their benefits, and that your office does not have the time and resources to verify each patient’s benefits; however, those arguments will not increase your revenue. Consider your understanding of your own insurance policy, and you can see that it is not black and white. Most patients receive little to no guidance regarding the specifics of their benefits, and they rarely expect to have separate benefits for office visits, procedures, radiology, and surgery. Despite that, many insurance plans pay office visits at 100 percent, and apply a deductible or co-insurance to in-office procedures or radiology; and the patients do not take responsibility when they receive a bill. For example, it is not uncommon for a patient to say that, had they known there was a deductible or co-insurance for a procedure, they would have refused it at the time of service. In that case, providers have few options. They can put the patient in collections, write off their balance as a courtesy, or give the patient a permanent spot on their accounts receivable report. Either way, they don’t get paid. Obviously if you want to get paid for every billable service you provide, the burden falls on your office to understand each patient’s benefits.

Commercial carriers offer a variety of online and telephone resources which give a basic description of covered services, including provider services lines, which allow you to speak with a person for detailed descriptions. And while verifying coverage can take time, it will increase competency and customer service which, in turn, will enhance your revenue and professional brand.
I MAY NOT BE ABLE TO SEE YOU ANYMORE.

Your insurance plan is cutting me out of its network. Simply stated, the insurance companies are putting profits before patients!

I want to continue to take care of you, but I need your help.

Several Medicare HMOs like United, Empire BCBS, and Emblem have dropped countless physicians from their networks in New York and across the country. I am fighting to protect your right to see the physician of your choice. We have informed Congress and the media that the unfair dropping of doctors from your Medicare Advantage plan will cause disruptions to our long-standing, patient-physician relationship.

You have two options.
• You can switch to another Advantage plan that I am in; or
• Revert to original Medicare

For help, call: 1-800-MEDICARE

We urge you to call your member of Congress as well as Senators Schumer and Gillibrand to protect your right to see the doctor of your choice!

To contact Senator Schumer, call: 202-224-6542
To contact Senator Gillibrand, call: 202-224-4451

To find out who your Representative is, go to: http://capwiz.com/mssny/state/main/?state=NY
What would the “Medicare Patient Empowerment Act” achieve?
The “Medicare Patient Empowerment Act” would establish a Medicare payment option for patients and physicians (and practitioners) to freely contract, without penalty, for Medicare fee-for-service physician and practitioner services, while allowing Medicare patients to use their Medicare benefits and allowing physicians to bill the patient for all amounts not covered by Medicare. Physicians and practitioners could continue to elect Medicare participating (PAR) or nonparticipating (non-PAR) status for other patients they treat.

Why is this legislation needed?
For over a decade, physicians have been threatened with huge cuts in Medicare payment rates due to the flawed Medicare physician payment formula, the sustainable growth rate (SGR), only for Congress to act at the 11th hour with a temporary patch that grows the problem and increases the cost of a permanent solution. From 2003 through 2011, Congress acted 13 times to avert steep Medicare physician payment cuts. In several instances the scheduled payment cut had already become effective and the temporary legislative fix was applied retroactively, creating serious administrative billing difficulties and cash flow problems for physician practices. Moreover, the Centers for Medicare & Medicaid Services recently acknowledged that Medicare pays less than half of direct costs for practice expenses (clinical staff, and medical equipment and supplies) for all physicians’ services. Existing Medicare underpayments, coupled with the threat of continued steep payment cuts, present serious access to care and choice of physician problems because fewer physicians will be able to afford to furnish services to Medicare patients. With baby boomers entering Medicare, alternative solutions to the physician payment problem are critical. If solutions are not found, new—and even current—Medicare patients will not be able to find a physician to treat them. Access to care and freedom to choose a physician have been key hallmarks of the Medicare program, and now these tenets may disappear. A new approach, such as the “freedom to contract” approach taken in this legislation, would:

- Provide patients with more choice of physicians
- Increase the number of physicians who will continue to accept Medicare patients
- Help address physician shortages by attracting physicians into the medical profession
- Help preserve our Medicare program, along with patient-centered care, for our elderly and disabled patients

How would the patient and physician contracting arrangement work?
Under the legislation, Medicare patients would have access to the physician of their choice and could contract with their physician outside of the Medicare program, without being denied their Medicare benefits. The contract would specify the payment due for services the physician provides to the patient, and the patient would be responsible for paying the physician the amount specified for each service, either up front or at periodic intervals, as agreed to under the contract. Unlike current Medicare private contracting law, however, patients would continue to have access to their Medicare benefits, and would receive the Medicare-allowed payment for each service. Medicare balance billing limits would not apply to any additional amounts due under the contract.

Who would be responsible for submitting claims to Medicare for the physicians’ services furnished under the contract?
Upon agreement by the patient and the physician the contract would specify whether the patient would file claims with Medicare or whether the physician would file the claims on the patient’s behalf.

Would this legislation allow patients to assign Medicare payment to their physician for services furnished under the contract?
Yes. The legislation would allow the patient to assign Medicare payment to the physician regardless of who files the claim, and this assignment would be specified in the contract. The patient would then be responsible for any amounts not paid by Medicare.
Would physicians be required to “opt out” of Medicare for all patients if the physician enters into a contract with a patient?

No. If a physician contracts with a patient, the physician would only “opt out” of Medicare for that patient. The physician, however, could continue as a Medicare PAR or non-PAR physician with respect to other patients.

How much would Medicare pay patients for the physicians’ services?

Medicare claims would be paid directly to the beneficiary in the amount that would apply to a Medicare participating (PAR) physician or practitioner in the Medicare payment area where the physician or practitioner resides. Payments would not be adjusted to reflect any incentive/penalty payments that might otherwise apply relating to the Physician Quality Reporting System (PQRS), electronic prescribing, and health information technology or cost-quality payment modifier programs.

If a physician contracts with a patient, will Medicare requirements apply to the physician as if the physician were a Medicare PAR or non-participating (non-PAR) physician since the patient may receive Medicare benefits and/or assign Medicare payment to the physician under the contract?

No. If a physician contracts with a patient, the physician is not considered a Medicare PAR or non-PAR physician, and therefore Medicare requirements would not apply to the physician for purposes of services furnished under the contract. (If the physician is a PAR or non-PAR physician for other patients, the physician would have to comply with Medicare requirements for services furnished to those patients.)

Would the legislation ensure that patients can contract on a level playing field? Are patient protections included in the legislation?

Yes, patient protections to promote a level playing field are included in the bill. For example, contracts could not be entered into when a patient is facing an “emergency medical condition” or “urgent health care situation.” Nor could low-income Medicare and Medicaid dual-eligible patients enter into a contract with their physician. Additional patient protections would require: 1) a written, signed contract that specifies the physician fees before services are furnished and the patient would be held harmless for any amounts billed in excess of the fees specified in the contract; and 2) indicating in the contract whether the physician is excluded from participation under Medicare.

Patients could not enter into a contract with a physician when facing an “emergency medical condition” or “urgent health care situation.” What would constitute an “emergency medical condition” or an “urgent health care situation”?

The legislation defines these terms consistent with definitions that are already part of Medicare policy. The term “emergency medical condition” is defined as “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part. The term “urgent health care situation” is defined as “services furnished to an individual who requires services to be furnished within 12 hours in order to avoid the likely onset of an emergency medical condition.”

Can emergency or urgent care services be covered under the contract if the contract is entered into before a patient faces any emergency or urgent health care situation?

Yes. As long as the contract is entered into before an emergency or urgent health care situation arises, the contract would cover all services furnished by the physician as long as the contract meets all other requirements, including the specification of payment that is due for the physicians’ services, including emergency and urgent health care services.

If payment for services established under the contract are more than the Medicare-allowed payment, can Medicare or state law prohibit or limit amounts that can be balance billed?

No. Medicare balance billing limits would not apply to amounts billed under the contract and the legislation would also pre-empt state laws that prohibit or limit balance billing.

How would this legislation help or benefit a physician who is employed by a hospital or large health system?

The Medicare Patient Empowerment Act clearly offers potential benefits for physicians in private practice and their patients. However, depending on the unique structure and employment agreements between individual physicians and their hospital or health system, there may be various legal and regulatory barriers that prevent these physicians and their patients from deriving the full benefits of the MPEA.
As the legislation moves through the legislative and regulatory implementation process, the AMA will advocate for solutions that provide the means for employed physicians to enter into personal contracts with patients.

**How is this legislation different from existing Medicare law?**

The legislation differs from existing Medicare law in three key respects:

1) Existing Medicare private contracting law requires a physician to “opt out” of Medicare for all patients for two years if even one patient enters into a private contract with a physician. Under this legislation, the physician would “opt out” of Medicare only with regard to the patient with whom the physician has a contract. The physician could continue to participate in Medicare with regard to other patients.

2) Existing Medicare private contracting law disadvantages Medicare patients who enter into a private contract with a physician because the patient is denied all Medicare benefits, despite having paid into the program for many years. This legislation would allow the patient to continue receiving their Medicare benefits under a contracting arrangement with a physician.

3) Existing Medicare balance billing law strictly limits the amount that a physician can balance bill a patient for charges that are greater than what Medicare pays for a service. Under this legislation, federal and state balance billing limits would not apply.

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Office is centrally located on Jericho Turnpike and has ample parking.

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The Medicare Patient Empowerment Act
(Continued from page 30)

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